PROVIDER PRICE VARIATION FOR MAMMOGRAPHY SERVICES IN THE COMMERCIAL MARKET

TECHNICAL APPENDIX

CHIA
center for health information and analysis

Data Year: Calendar year (CY) 2012 incurred; paid through June 30, 2013

Data Source: Massachusetts All-Payer Claims Database (MA APCD)[1] Medical Claims and Provider Files

The analytic data source was constructed with CY2012 medical claims according to date of service linked to the provider file by billing provider ID. The data consisted of claims for mammography procedures for Massachusetts residents with commercial insurance coverage from the three largest commercial payers in Massachusetts: Blue Cross Blue Shield of Massachusetts (BCBS), Harvard Pilgrim Health Care (HPHC), and Tufts Health Plan (Tufts). Recipients of mammography services were primarily female, though the data source was not specifically filtered for females. Medical claims included fully and self-insured commercial members of these three payers. Capitated claims and claims paid at reduced amounts as indicated by procedure modifier values were excluded.

The data source contained predominantly five procedure codes associated with digital mammography: G0202, G0204, and G0206 for X-rays and 77051 and 77052 for computer interpretation add-ons. Film mammography codes 77055, 77056, and 77057 were also analyzed. Digital mammography has become the industry standard for screening and diagnostic mammography. Film mammography represents less than a percent of all mammography spending among the top 3 payers and only a few providers are still providing film services. Thus, film mammography was excluded from this brief.

Definitions:

Acute Hospital: a provider type for a mammography procedure determined by a facility claim billed by an acute hospital. The professional claim component of the procedure may have been billed by another provider associated with the facility.

Computer Interpretation Add-on: an additional procedure reported with mammography procedures for computer-aided detection with physician review (represented by CPT codes 77051 and 77052).

Diagnostic Mammography: an X-ray of the breast after finding a lump or other symptom to evaluate for breast cancer.

Digital Mammography: an electronic X-ray of the breast which allows the image to be captured and stored directly on a computer (represented by HCPC codes G0202, G0204, and G0206).

Facility Claim (Facility Component): also called the Technical Component. Represents the cost of rent, equipment, utilities, supplies, administrative and facility salaries and benefits, and other overhead expenses of the procedure.

Film Mammography: an X-ray of the breast that is captured and produced on film (represented by CPT codes 77055, 77056, and 77057).

Imaging Center: a provider type for a mammography procedure determined by a facility claim billed by a diagnostic imaging center. The professional claim component of the procedure may have been billed by another provider associated with the facility.

Modifier: a two-digit value reported with a procedure code that indicates that the procedure has been altered, but does not change the definition of the procedure, though the value may affect the reimbursement amount.

Physician Office: a provider type for a mammography procedure determined by a facility claim billed by a physician office or group. The professional claim component of the procedure may have been billed by another provider associated with the facility.

Professional Claim (Professional Component): represents the physicians' work interpreting or performing the procedure.

Screening Mammography: an X-ray of the breast used for early detection of breast cancer for women who have no symptoms.

1 CHIA maintains the MA APCD pursuant to M.G.L., Chapter 12C, Section 10. Information on the MA APCD is available at www.mass.gov/chia/apcd.

Methods:

Prices include the amount paid by insurers plus patient liabilities. Patient liabilities include co-insurance, deductible, and co-pay amounts.

The provider of a mammography procedure and the associated provider type were determined by the facility claim billed for the provider. The professional claim component of the procedure was commonly billed to another provider associated with the facility. For example, consider a mammography procedure performed at an acute hospital. The facility claim was billed by the hospital and the professional claim was billed by the physician group of the physician who performed the procedure. Alternatively for ambulatory care providers, the facility component and the professional component may have been billed in one claim to one provider (e.g. a physician office or an imaging center) and paid at a global price amount. When the facility claim and professional claim were billed to separate providers, they were combined to compare the full price paid for a mammography X-ray.

Provider reporting focused on high-volume acute hospitals, physician offices, and imaging centers, which represented about 97.4% of all provider procedures. An additional 2.6% of procedures performed by community health centers, individual practitioners, out-of-state providers, and other low volume providers were grouped as "All Other" for provider type reporting.

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